



Maryland Department of Health and Mental Hygiene  
Office of Health Care Quality – Laboratory Licensing Programs  
Spring Grove Center – Bland Bryant Building  
55 Wade Avenue, Catonsville, MD 21228  
Phone: 410.402.8025 Fax: 410.402.8213

Office Use Only

Date Received:

Check #:

Amount:

Date Completed:

## Laboratory Licensing Change Form

This form is for changes and updates only. Please only provide us with the changes in the fields below along with the effective date of the change.

For a change of Director, a copy of the Director's medical license, medical diploma and board certification must be submitted. Please send diploma and CV for a PhD Director. This form must be signed by the Director for these changes to be valid.

**\*\*\*THIS FORM MUST BE SIGNED BY THE DIRECTOR FOR ALL CHANGES TO BE VALID.\*\*\***

Please return this form by fax:  
410-402-8213

Or by email:  
paul.celli@maryland.gov

Current Name of Lab: \_\_\_\_\_

State Lab ID # \_\_\_\_\_ Federal CLIA #: \_\_\_\_\_ Is this CLIA a multisite? Y N

Laboratory Name: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Owner: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Director: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Date of Change: \_\_\_\_\_  
\_\_\_\_\_

Mailing/Billing Address: \_\_\_\_\_ Date of Change: \_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Fax #: \_\_\_\_\_ Date of Change: \_\_\_\_\_

Please list the tests you are adding or deleting from your current test menu. Please use the chart below and indicate for each test the instrument/kit used as well as the effective date of change.

### Changes/Additions/Deletions to Tests

Test Name	Kit/Instrument Used	Add	Delete	Date of Change
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Change State License Status to:

☐ Letter of Exception

☐ General Permit

Date of Change: \_\_\_\_\_

Change my CLIA Certification Status to: (must submit with a CMS-116)

☐ Waiver

☐ Compliance

☐ Provider Performed Microscopic Procedures (PPMP)

☐ Accreditation with which program? \_\_\_\_\_

Date of Change: \_\_\_\_\_

Our office has closed and/or discontinued all clinical testing. Date of Change: \_\_\_\_\_

Print Laboratory Director's Name: \_\_\_\_\_

Laboratory Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_